General Assembly

Raised Bill No. 5569

February Session, 2002

LCO No. **1821**

Referred to Committee on Insurance and Real Estate

Introduced by:
(INS)

AN ACT CONCERNING HEALTH INSURANCE CLAIMS AND PAYMENT RECOVERY.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subdivision (15) of section 38a-816 of the general statutes, as amended by public act 01-111 and section 43 of public act 01-4 of the June special session, is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(15) (A) Failure by an insurer, or any other entity responsible for providing payment to a health care provider pursuant to an insurance policy, to pay accident and health claims, including, but not limited to, claims for payment or reimbursement to health care providers, within the time periods set forth in subparagraph (B) of this subdivision, unless the Insurance Commissioner determines that a legitimate dispute exists as to coverage, liability or damages or that the claimant has fraudulently caused or contributed to the loss. Any insurer, or any other entity responsible for providing payment to a health care provider pursuant to an insurance policy, who fails to pay such a claim

or request within the time periods set forth in subparagraph (B) of this subdivision shall pay the claimant or health care provider the amount of such claim plus interest at the rate of fifteen per cent per annum, in addition to any other penalties which may be imposed pursuant to sections 38a-11, 38a-25, 38a-41 to 38a-53, inclusive, as amended, 38a-57 to 38a-60, inclusive, 38a-62 to 38a-64, inclusive, 38a-76, 38a-83, 38a-84, 38a-117 to 38a-124, inclusive, 38a-129 to 38a-140, inclusive, 38a-146 to 38a-155, inclusive, as amended, 38a-283, 38a-288 to 38a-290, inclusive, 38a-319, 38a-320, 38a-459, 38a-464, 38a-815 to 38a-819, inclusive, as amended, 38a-824 to 38a-826, inclusive, and 38a-828 to 38a-830, inclusive. Whenever the interest due a claimant or health care provider pursuant to this section is less than one dollar, the insurer shall deposit such amount in a separate interest-bearing account in which all such amounts shall be deposited. At the end of each calendar year each such insurer shall donate such amount to The University of Connecticut Health Center.

(B) Each insurer, or other entity responsible for providing payment to a health care provider pursuant to an insurance policy subject to this section, shall pay claims not later than forty-five days after **[**receipt by the insurer of**]** the insurer receives the claimant's proof of loss form or the health care provider's request for payment filed in accordance with the insurer's practices or procedures, except that when there is a deficiency in the information needed for processing a claim, the insurer shall (i) send written notice to the claimant or health care provider, as the case may be, of all alleged deficiencies in information needed for processing a claim not later than thirty days after the insurer receives a claim for payment or reimbursement under the contract, and (ii) pay claims for payment or reimbursement under the contract not later than thirty days after the insurer receives the requested information. **[**requested.**]**

(C) After a claim is paid, no insurer may seek to recover payment unless (i) the insurer sends written notice to the claimant or health care provider, as the case may be, (ii) the notice indicates the insurer's

intent to recover payment and identifies the claim, and (iii) the notice is sent not later than one hundred twenty days after the date the insurer paid the claim.

[(C)**]** (D) As used in this subdivision, "health care provider" means a person licensed to provide health care services under chapter 368v, chapters 370 to 373, inclusive, 375 to 383c, inclusive, 384a to 384c, inclusive, or chapter 400j.

Sec. 2. Subdivision (1) of section 38a-226 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(1) "Utilization review" means the prospective, **[**or**]** concurrent or retrospective assessment of the necessity and appropriateness of the allocation of health care resources and services given or proposed to be given to an individual within this state. Such assessment may include, but is not limited to, matters relating to coverage, medical necessity, medical appropriateness, health care setting, level of care, medical efficacy and technical compliance with the practices and procedures set forth in a policy, contract or plan. Utilization review shall not include elective requests for clarification of coverage.

Sec. 3. Subsection (a) of section 38a-226c of the general statutes, as amended by section 5 of public act 01-174, section 179 of public act 01-195, section 3 of public act 01-124 and section 7 of public act 01-139, is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) All utilization review companies shall meet the following minimum standards:

(1) Each utilization review company shall maintain and make available procedures for providing notification of its determinations regarding certification in accordance with the following:

(A) Notification of any prospective determination by the utilization

review company shall be mailed or otherwise communicated to the provider of record or the enrollee or other appropriate individual within two business days of the receipt of all information necessary to complete the review, provided any determination not to certify an admission, service, procedure or extension of stay shall be in writing. When there is a deficiency in the information necessary for completing the review, the utilization review company shall (i) send written notice to the appropriate individual of all alleged deficiencies in information needed for completing the review not later than five business days after the utilization review company receives a request for review, and (ii) complete the review not later than five business days after the utilization review company receives the information requested. After a prospective determination that authorizes an admission, service, procedure or extension of stay has been communicated to the appropriate individual, based on accurate information from the provider, the utilization review company may not reverse such determination if such admission, service, procedure or extension of stay has taken place in reliance on such determination.

(B) Notification of a concurrent determination shall be mailed or otherwise communicated to the provider of record within two business days of receipt of all information necessary to complete the review or, provided all information necessary to perform the review has been received, prior to the end of the current certified period and provided any determination not to certify an admission, service, procedure or extension of stay shall be in writing.

(C) The utilization review company shall not make a determination not to certify based on incomplete information unless it has clearly indicated, in writing, to the provider of record or the enrollee all the information that is needed to make such determination.

(D) Notwithstanding subparagraphs (A) to (C), inclusive, of this subdivision, the utilization review company may give authorization orally, electronically or communicated other than in writing. If the

determination is an approval for a request, the company shall provide a confirmation number corresponding to the authorization.

(E) Any notice of a determination not to certify an admission, service, procedure or extension of stay shall include in writing (i) the principal reasons for the determination, (ii) the procedures to initiate an appeal of the determination or the name and telephone number of the person to contact with regard to an appeal pursuant to the provisions of this section, and (iii) the procedure to appeal to the commissioner pursuant to section 38a-478n.

(2) Each utilization review company shall maintain and make available a written description of the appeal procedure by which either the enrollee or the provider of record may seek review of determinations not to certify an admission, service, procedure or extension of stay. The procedures for appeals shall include the following:

(A) Each utilization review company shall notify in writing the enrollee and provider of record of its determination on the appeal as soon as practical, but in no case later than thirty days after receiving the required documentation on the appeal.

(B) On appeal, all determinations not to certify an admission, service, procedure or extension of stay shall be made by a licensed practitioner of the medical arts.

(3) The process established by each utilization review company may include a reasonable period within which an appeal must be filed to be considered.

(4) Each utilization review company shall also provide for an expedited appeals process for emergency or life threatening situations. Each utilization review company shall complete the adjudication of such expedited appeals within two business days of the date the appeal is filed and all information necessary to complete the appeal is

received by the utilization review company.

(5) Each utilization review company shall utilize written clinical criteria and review procedures which are established and periodically evaluated and updated with appropriate involvement from practitioners.

(6) Physicians, nurses and other licensed health professionals making utilization review decisions shall have current licenses from a state licensing agency in the United States or appropriate certification from a recognized accreditation agency in the United States, provided, any final determination not to certify an admission, service, procedure or extension of stay for an enrollee within this state, except for a claim brought pursuant to chapter 568, shall be made by a physician, nurse or other licensed health professional under the authority of a physician, nurse or other licensed health professional who has a current Connecticut license from the Department of Public Health.

(7) In cases where an appeal to reverse a determination not to certify is unsuccessful, each utilization review company shall assure that a practitioner in a specialty related to the condition is reasonably available to review the case. When the reason for the determination not to certify is based on medical necessity, including whether a treatment is experimental or investigational, each utilization review company shall have the case reviewed by a physician who is a specialist in the field related to the condition that is the subject of the appeal. Any such review, except for a claim brought pursuant to chapter 568, that upholds a final determination not to certify in the case of an enrollee within this state shall be conducted by such practitioner or physician under the authority of a practitioner or physician who has a current Connecticut license from the Department of Public Health. The review shall be completed within thirty days of the request for review. The utilization review company shall be financially responsible for the review and shall maintain, for the commissioner's verification, documentation of the review, including the name of the reviewing

physician.

(8) Except as provided in subsection (e) of this section, each utilization review company shall make review staff available by toll-free telephone, at least forty hours per week during normal business hours.

(9) Each utilization review company shall comply with all applicable federal and state laws to protect the confidentiality of individual medical records. Summary and aggregate data shall not be considered confidential if it does not provide sufficient information to allow identification of individual patients.

(10) Each utilization review company shall allow a minimum of twenty-four hours following an emergency admission, service or procedure for an enrollee or **[**his**]** the enrollee's representative to notify the utilization review company and request certification or continuing treatment for that condition.

(11) No utilization review company may give an employee any financial incentive based on the number of denials of certification such employee makes.

(12) Each utilization review company shall annually file with the commissioner (A) the names of all managed care organizations, as defined in section 38a-478, that the utilization review company services in Connecticut, (B) any utilization review services for which the utilization review company has contracted out for services and the name of such company providing the services, and (C) the number of utilization review determinations not to certify an admission, service, procedure or extension of stay and the outcome of such determination upon appeal within the utilization review company. Determinations related to mental or nervous conditions, as defined in section 38a-514, shall be reported separately from all other determinations reported under this subdivision.

(13) Any utilization review decision to initially deny services shall be made by a licensed health professional.

Sec. 4. Section 38a-483b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

Except as otherwise provided in **[**this title**]** chapter 698a, each insurer, health care center, hospital and medical service corporation or other entity delivering, issuing for delivery, renewing or amending any individual health insurance policy in this state on or after January 1, 2000, providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 shall complete any coverage determination with respect to such policy and notify the insured or the insured's health care provider of its decision not later than forty-five days after a request for such determination is received by the insurer, health care center, hospital and medical service corporation or other entity. If there is a deficiency in the information needed for making a decision, the entity shall (1) send written notice to the insured or provider of all alleged deficiencies in information needed for making a decision not later than thirty days after the entity receives a request for a coverage determination, and (2) notify the insured or provider of its decision not later than thirty days after receiving the information requested. In the case of a denial of coverage, such entity shall notify the insured and the insured's health care provider of the reasons for such denial.

Sec. 5. Section 38a-513a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

Except as otherwise provided in **[**this title**]** chapter 698a, each insurer, health care center, hospital and medical service corporation or other entity delivering, issuing for delivery, renewing or amending any group health insurance policy in this state on or after January 1, 2000, providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 shall complete any coverage determination with respect to such policy and notify the insured or the

insured's health care provider of its decision not later than forty-five days after a request for such determination is received by the insurer, health care center, hospital and medical service corporation or other entity. If there is a deficiency in the information needed for making a decision, the entity shall (1) send written notice to the insured or provider of all alleged deficiencies in information needed for making a decision not later than thirty days after the entity receives a request for a coverage determination, and (2) notify the insured or provider of its decision not later than thirty days after receiving the information requested. In the case of a denial of coverage, such entity shall notify the insured and the insured's health care provider of the reasons for such denial.

This act shall take effect as follows:	
Section 1	*from passage*
Sec. 2	*from passage*
Sec. 3	*from passage*
Sec. 4	*from passage*
Sec. 5	*from passage*

Statement of Purpose:

To revise statutory time limits for insurers to review and pay certain health claims.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]